MINUTES
PSYCHIATRIC & SUBSTANCE ABUSE INPATIENT SERVICES
TECHNICAL ADVISORY COMMITTEE
Of the Health Strategies Council
2 Peachtree Street, 34th Floor Conference Room
Atlanta, GA 30303

December 9, 2005
10:00 am - 1:00 pm

William "Clay" Campbell, Chair, Presiding

MEMBERS PRESENT

Joel Axler, MD
Ruby Durant (for Carol Zafiratos)
Paul Hackman
Roslind Hudson
Doris Patillo, L.P.C.
Mary Lou Rahn, B.S.N.
Robin Robinson
Mark Scott, R.N.
Wayne Senfeld, ED.S, L.P.C
Sandra Sexson, MD
Mary Ann Smith, RN
Pat Strode

MEMBERS ABSENT

Ray Heckerman, M.S.
Gary Howard
Brenda Reid, R.N., C.C.M.

GUESTS PRESENT

Craig Armstrong, Gwinnett Hosp. System
Lisa Norris, The Strategy House
Helen Sloat, Nelson Mullins
Leah Watkins, Powell Goldstein

STAFF PRESENT

Rory Gagan
Charemon Grant, JD
Richard Greene, JD
Matthew Jarrard, MPA
Brigitte Maddox
Yuvonica Ransom
Robert Rozier, JD
Rhathelia Stroud, JD
Stephanie Taylor, MPS

WELCOME AND INTRODUCTIONS

The meeting commenced at 10:15 am. The Chair called on committee members, Department staff and guests to introduce themselves.

APPROVAL OF MINUTES OF OCTOBER 28TH MEETING

A motion to accept the minutes of the October meeting was made by Dr. Sexson, seconded by Paul Hackman.

OUTLINE OF THE PLANNING PROCESS

Mr. Campbell called on Stephanie Taylor to review the committee's planning process. Ms. Taylor noted that the *Statutory and Regulatory Framework* document, included in today's meeting packet, would be used to direct the committee's work. She said that this document parallels the current Psychiatric & Substance Abuse Inpatient Services Rules and highlights the standards that members would be reviewing throughout this planning and development process.

BRIEF OVERVIEW OF INDUSTRY TRENDS IN PSYCHIATRIC & SUBSTANCE ABUSE SERVICES

Mr. Campbell called upon Dr. Axler to provide a brief overview of industry trends thus providing the TAC a better understanding of current industry challenges. Some highlights of his presentation include the following:

- Great statewide need for services for child and adolescent programs;
- Payment mechanisms for psychiatric and substance abuse inpatient services seriously challenged;
    a. Medicare provides reimbursement, under limited circumstances.
    b. Services primarily funded by state dollars.
- Greater need for services across the continuum of care services.
- State hospitals do not provide medical care

Department staff indicated that the current Rules indicate that psychiatric & substance abuse inpatient services must be provided in a licensed facility and asked members to identify other types of facilities where these services could be provided. Committee members noted that psychiatric and substance abuse services also could be provided in the following settings:

- Group homes
- Drug treatment facilities
- Halfway Houses

During the committee's discussion, Mary Lou Rahn provided the following overview of Crisis Stabilization Programs in Georgia noting that the goals of these programs are to prevent unnecessary hospitalization or re-hospitalization, to provide psychiatric and substance abuse stabilization, and to link patients to appropriate services for ongoing support and care. She said that these programs are a huge support to local communities and to existing programs. A summary of her review of these programs include the following:

- Provide medically monitored short-term residential psychiatric stabilization and detoxification services.
- Designed as an alternative to hospitalization in state hospitals and to serve patients locally for crises that were not severe enough to require hospitalization.
- Used to serve patients that are transitioning from state or local community hospitals;

- Designated by the Division of Mental Health, Developmental Disabilities and Addictive Diseases (Division of MHDDAD) as both emergency receiving and evaluation facilities.
- Surveyed (every two years) and certified by the Division of MHDDAD.
- Operated by Community Service Boards and are state operated.
    - Average length of stay should not exceed ten (10) days; excluding Saturdays, Sundays and holidays.
- Ninety-five percent (95%) of monies must be public funds, largely state Grant-in-Aid followed by Medicaid billing for the Medicaid eligible.

Department staff inquired whether these programs compete with other similar programs that are currently required to submit a Certificate of Need (CON). Committee members agreed that these programs are of tremendous support to existing community programs. Some members expressed concern about the lack of continuity of care mechanisms in these programs, noting that they do not offer a wide range of services.

Department staff asked whether requiring CON for crisis stabilization programs would help to ensure continuity of care. Members felt that there is no need to require CON for these programs.

FOLLOWUP ON TAC DATA REQUESTS AND EXPLANATION OF NEED METHODOLOGY

Mr. Campbell called on Matthew Jarrard to review the data and other materials in member packets. Mr. Jarrard reviewed several maps which provide a depiction of the state's adult and children's psychiatric and substance abuse inpatient and adult and adolescent extended care programs.

Mr. Jarrard also reviewed data relating to capacity and utilization of adult, and child and adolescent programs. Members noted that the statewide occupancy rates are deceiving and said that the data does not provide an accurate assessment of the statewide staffing patterns or occupancy rates. Members indicated that beds are sometimes "blocked" due to patient diagnosis and/or staffing constraints or other factors including patient's sex (male/female), age or # of beds/room. They recommended that data for these facilities be collected utilizing set-up-staffed (SUS) beds as opposed to CON approved beds. Department staff indicated that CON approved beds are used in the calculation of the need methodology because that number is constant and should not be changed without the issuance of another CON. SUS beds can be changed at the facility's discretion. Mr. Rozier said that a mechanism to address this problem would be for the Department to continue to use the CON approved beds in the need methodology but if the full complement of CON approved beds are not used for the most recent 12-month period that those beds could be taken out of the inventory and would be considered closed. He noted that such a Rule could not be applied retroactively but would apply to all new applications. Members agreed to this recommendation, but no vote was taken.

Mr. Jarrard reviewed the current need methodology for Acute Psychiatric and Substance Abuse Inpatient Programs. He indicated the following:

- Current methodology uses the Graduate Medical Education National Advisory Committee (GMENAC) to establish rates of persons requiring acute hospitalization and to project the number of expected admissions to acute psychiatric and substance abuse inpatient programs.
- Prevalence rates are included in the need calculation.
- Because of differences in patient selection for public and private providers, the numerical need methodology is calculated separately for these two types of facilities.
    - Public Sector:
        - The mental health regions are used as planning areas for the public sector.

        - Patients receiving care in public facilities are generally admitted to the state regional hospital serving their mental health region.
        - Most admissions to state regional hospitals are for residents from the hospital's designated mental health region; therefore, patient flow between mental health regions and from out-of-state are not considered in the bed need methodology.
    - Private Sector:
        - Because residents of one planning area may seek care provided in any planning area, patient flow patterns between areas and from out-of-state are considered when determining need.
- Aggregate utilization in the planning area is considered in both methodologies. No additional need for services would be considered, unless the following percentage utilization is reached for each program.
    - Adult programs – 80%
    - Adolescent/child programs – 75%
    - Extended care programs – 85%

Committee members indicated that more recent data from the Surgeon General's Report should be used in lieu of the GMENAC study. They also recommended that data sets from Requests for Proposals (RFPs) for both the Medicaid and State Health Benefit Programs should be considered. Members also requested information about the numerical need methodologies that are used in other states, as a basis of comparison.

DISCUSSION OF GEORGIA'S REGULATORY FRAMEWORK AND REVIEW CRITERIA

Mr. Campbell called on Stephanie Taylor and Robert Rozier to continue the discussion regarding other standards contained in the current Rules. Ms. Taylor noted that in addition to the numerical need methodology, other standards are considered when reviewing CON applications for these services, including the following:

Exception to Need- typically allows a provider to substantiate the need for additional services based on cost, quality, financial access, or geographic accessibility standards. She noted that this language is standard and is contained in the Rules for other CON services.

Ms. Taylor clarified that when the applicant is a general hospital, two sets of Rules are applied in the CON review process, namely, the Rules governing the need for Short Stay General Hospital beds and the Rules for Psychiatric & Substance Abuse Inpatient programs.

Financial Feasibility: Department staff noted that in addition to the need, the applicant must provide documentation that the program is financially feasible, which would include information on projected utilization and current utilization of existing programs. Department would examine the application to determine whether costs and charges are reasonable and would examine payor mix and occupancy rates. Levels of trained staff and adequacy of facility space would also be examined. Staff further noted that the Department would consider whether the service would have a negative impact on payors and require that applicants submit their proposed charges. The Department would compare the proposed charges (to other applications for similar services in the planning area) to determine whether proposed charges are reasonable. Department staff indicated that this requirement was written during the time of cost-based reimbursement and recognized that "charges" are essentially meaningless, since providers can charge whatever fees they would like. Department staff also noted that the applicant's policies regarding self-pay patients and how payment mechanisms and dispute resolutions would be handled are part of the review process.

Members agreed that the submission of the applicant's policy would be enough to satisfy this standard since proposed charges are meaningless.

Committee members asked whether the Department could revoke a CON if these standards are not met. Department staff emphasized that the Department has no statutory authority to revoke a CON if quality standards are not met.

Continuum of Care Services- Department staff confirmed that the applicant would be required to provide their policies governing admissions and to ensure that an adequate discharge planning process is in place.

Provision of indigent & charity care- Department staff stated that current Rules require that psychiatric and substance abuse inpatient programs must be provided in a licensed hospital. In addition, hospital facilities are required to provide a three-percent (3%) hospital-wide indigent & charity care commitment in addition to a three-percent (3%) commitment for psychiatric services. Staff said that this is a mechanism to ensure that all providers share the burden of providing care to all Georgia residents.

Some members said that freestanding psychiatric facilities do not accept Medicaid. Some members expressed concern about continuity of care for patients in those settings.

Minimum Bed Size- Department staff noted that minimum bed size was established to ensure that services are provided in an efficient and cost effective manner. Also, due to the need for specialized staff, facilities would not likely be able to support very small programs. Staff reviewed the current minimum bed size requirements in the Department Rules including the following:

- New acute psychiatric or substance abuse (extended care programs) – 8 beds
- Freestanding psychiatric or substance abuse hospital – 50 beds
- Psychiatric &/or substance abuse in a general hospital – 15 beds

Members inquired about the origin of these standards and how these numbers were derived. Department staff indicated that the minimum bed size recommendations were determined by a prior technical advisory committee.

Some members recommended that the minimum number of beds could be reduced for general hospitals. Members said 8-10 beds would be more appropriate for applicants from general hospitals for adult and child and adolescent programs.

Robin Robinson noted that there is some case law (*Kenny A. vs. State of Georgia, et.al.)* which members may want to consider in light of some of this discussion. She indicated that she would provide a copy of the case for distribution to committee members.

Positive impact on existing health care delivery - Department staff reviewed the standards an applicant could use to demonstrate that a service would have a positive relationship to the existing health care delivery system. Department staff encouraged committee members to review all current standards and to provide feedback at the next meeting.

IDENTIFICATION OF DATA AND ADDITIONAL INFORMATION

During the committee's deliberations, members requested the following data reports:

- Occupancy rates based on set-up-staffed (SUS) beds for Psychiatric and Extended care services.
- Occupancy rates, based on CON authorized beds for Psychiatric and Extended Care Services;
- Market Share Report.
- Maps, Acute Psychiatric & Substance Abuse Services and Maps, Child & Adolescent Extended Care Psychiatric Program.
- Step-by-step explanation of the Georgia's calculation of the numerical Need Methodology
- Sample, Need Methodologies of other states

Members also recommended the review of the following data sources that the Department could consider, in lieu of data recommendations from the GMENAC study:

- Data source used for the Medicaid RFP
- Data source used by State Health Benefit Plan

PUBLIC COMMENTS

W. Clay Campbell called on guests to provide public comment. No public comment was received.

UPCOMING MEETING DATES

Committee members have planned the next two meetings as follows:

- Friday, January 27, 2006; 10:00 am – 1:00 pm
- Friday, March 3, 10:00 am – 1:00 pm

ADJOURNMENT

There being no further business, the meeting adjourned at 12:55 pm.

Minutes taken on behalf of Chair by Stephanie Taylor.

Respectfully Submitted,

W. Clay Campbell, Chair